

**EMPLOYEE'S NOTIFICATION OF INTENT TO LEAVE LOCALITY
OR STATE, AND TO CHANGE DOCTOR OR HOSPITAL**

Mail completed form to:

STATE OF UTAH - LABOR COMMISSION

Division of Industrial Accidents

P.O. BOX 146610

Salt Lake City, UT 84114-6610

NOTICE: Injured employees should contact the insurance carrier prior to making plans to leave the state for medical care. THE CARRIER MAY NOT BE LIABLE FOR ANY OR ALL OF THE COSTS. Other states are not bound by our limitations on medical fees and you may have to pay the difference between what is allowed in Utah and what the new physician charges. If you have a question as to who the carrier is, ask your employer.

INCOMPLETE OR UNSIGNED FORMS WILL BE RETURNED.

NO ACTION WILL BE TAKEN UNTIL THE ATTENDING PHYSICIAN'S STATEMENT IS RECEIVED.

Name of Employer

Date of Injury

Street Address of Employer

Insurance Carrier

City, State, and Zip of Employer

Employer's Area Code and Telephone Number

Name of Employee (Printed)

Utah Street Address of Employee

New: Address of Employee

Utah City and Zip Code of Employee

New: City, State, and Zip Code of Employee

Utah Telephone #

Social Security #

New: Area Code and Telephone #

I left _____/intend to Leave _____ the State on (date) _____. I have _____ have not _____ reported
to my last Utah physician _____ for a current examination.

Physician's Full Name and Title

Physician's complete address, including zip code and office number

The physician's statement describing my condition when last examined is attached to this request [] will be mailed to your office by the physician [].

The treating physician that I have chosen in my new location is:

Dr. _____
Complete Name (including title)

Street address, Office Number, City, State, and Zip.

New Physician's Area Code and Telephone Number

Employee's Signature

Receipt acknowledged by: _____ Date: _____

Copies mailed to : _____

Street Address: Heber Wells Bldg, 160 East 300 South, 3rd Floor, Salt Lake City, UT